

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

2714

28

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty CharlesRegistered No. 106Village or City Marshall Hall No. _____

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William W. Blanchard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH unknown, 1880
(Month) (Day) (Year)

7 AGE 34 yrs. — mos. — ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Chas. Co.

10 NAME OF FATHER

William Blanchard

11 BIRTHPLACE OF FATHER (State or country)

Washington D.C.

12 MAIDEN NAME OF MOTHER

Emma Wade

13 BIRTHPLACE OF MOTHER (State or country)

Charles Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marshall Hall

(Address)

Marshall Hall Md

15

Filed

March 13, 1914John P. Marshall

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 12th, 1914.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 8th, 1914, to March 7th, 1914,that I last saw him alive on March 7th, 1914and that death occurred on the date stated above, at 6-10 P. m.,

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs(Duration) 2 yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. W. Mitchell, M. D.March 13th, 1914. (Address) Indian Head

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shilo Cem. PomfretMarch 14th, 1914

20 UNDERTAKER

ADDRESS

Albert LomasSoapstone Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

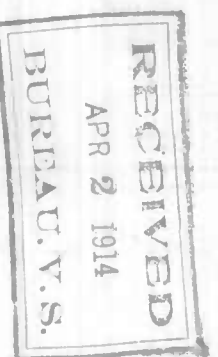
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 2715

County

Charles

93

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 102

Village or City

Grayton

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Robert Brooke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

March 1st

(Month)

(Day)

1895
(Year)

7 AGE

19

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farm Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

John Brooke

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Fanny Hooper

13 BIRTHPLACE OF MOTHER

(State or country)

Montgomery Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Brooke

(Address)

Grayton Md

15

Filed

March 14, 1914 William B Thompson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 13th

(Month)

(Day)

1914
(Year)

I HEREBY CERTIFY, That I attended deceased from

March 13, 1914

to

1914

that I last saw him alive on Feb 1st, 1914

and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Sick since last Oct 13.

Subsequent died by lying out all night on ground causing Pleurisy. Death from effects of same cough with effusion (Duration) yrs. mos. ds.

Contributory

Secondary

(Duration)

yrs. 5 mos. ds.

(Signed)

J. S. Speake

, M. D.

1914 (Address)

Grayton

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Emory Chapel

DATE OF BURIAL

Mar 15, 1914

20 UNDERTAKER

William B Thompson

ADDRESS

Concaste Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

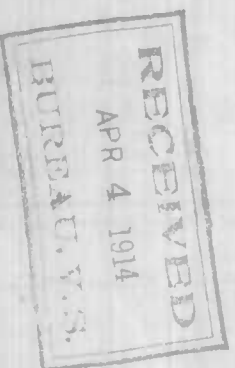
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2716

154

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Charles

Registration Dist. No.

112

Village or City

Gross Roads

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lee Ann Cooke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Widow*

6 DATE OF BIRTH *not exactly known supposed to be 1824*

7 AGE *90* yrs. or more mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Housewife as long as she was able to work* (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Maryland*

10 NAME OF FATHER *William Butler*

11 BIRTHPLACE OF FATHER (State or country) *Virginia*

12 MAIDEN NAME OF MOTHER *not known*

13 BIRTHPLACE OF MOTHER (State or country) *Virginia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant) *Sarah Simpson*(Address) *Gross Roads, Md.*

15

Filed *March 15, 1914* *Deputy Local* REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *March 15*, 191*4*

17 I HEREBY CERTIFY, That I attended deceased from *March 15*, 191*4*, to *March 15*, 191*4*, that I last saw him alive on *March 15*, 191*4*.

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Weakness due to old age

(Duration) yrs. mos. ds. Contributory *Due without the attendance of a Physician*

(Signed) *John J. Maddox*, M.D. (Address) *1508 Castorina*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL *Wm. Hope Church March 17*, 191*4*

20 UNDERTAKER ADDRESS *C. W. Thompson Soncaster Md.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 4 1914
BUREAU, V. S.

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1 PLACE OF DEATH
County CharlesVillage or City Grayton (No. 178)2 FULL NAME Noble CraigSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 102

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH

unknown
(Month) (Day) (Year)

7 AGE

5-6 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer, Farm

9 BIRTHPLACE (State or country)

md

PARENTS

10 NAME OF FATHER

Mae Craig

11 BIRTHPLACE OF FATHER (State or country)

md

12 MAIDEN NAME OF MOTHER

Emeline Barber

13 BIRTHPLACE OF MOTHER (State or country)

md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Brown
Grayton md
(Address)

15

Filed

Mar 6 1914
William B. Thompson
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 5, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

..... 191..... to 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Case of death was from asphyxiation by gas, entered night - no evidence of the poisoning (Duration) yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Francis E. Cunningham, M.D.
Conroe 191 (Address) Conroe md

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Grove Church March 7, 1914

20 UNDERTAKER

ADDRESS

William B. Thompson Conroe md

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

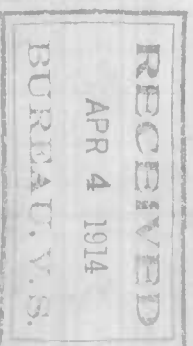
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1 PLACE OF DEATH

2718

153

County

Charles

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 106

Village or City

Waldorf

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

W. Anderson Fleet

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Jan. 11, 1914
(Month) (Day) (Year)

7 AGE

— yrs. 2 mos. 12 ds.

If LESS than

1 day, hrs.

OR mo. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Chas. C.

PARENTS

10 NAME OF FATHER

Robert Fleet

11 BIRTHPLACE OF FATHER
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Lena Dent

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Hood

(Address)

Waldorf Md

15

Filed

3/23

1914

T. M. Wilkerson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mch 23, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lack of Care

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. M. Wilkerson D.R., R.D.

3/23

1914 (Address) Waldorf Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Peter's Cemetery

3/24, 1914

20 UNDERTAKER

Hunt & Wynn

ADDRESS

Rev. Harry Hood

Waldorf Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc. When a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUREPURAL septicæmia," "PUREPURAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH <i>Charles</i>		2719	STATE OF MARYLAND CERTIFICATE OF DEATH	
County		Registration Dist. No. <i>103</i>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
Village or City <i>Deutschville</i> (No. _____) St.; _____ Ward)				
2 FULL NAME <i>Turner Goodrich</i>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Single</i> (Write the word)		
6 DATE OF BIRTH <i>Unknown</i> (Month) (Day) (Year)				
7 AGE <i>46?</i> yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Laborer</i> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <i>Charles Co.</i>				
PARENTS	10 NAME OF FATHER <i>J. M. Goodrich</i>			
	11 BIRTHPLACE OF FATHER (State or country) <i>Charles Co.</i>			
	12 MAIDEN NAME OF MOTHER <i>Martha Sharp</i>			
13 BIRTHPLACE OF MOTHER (State or country) <i>Charles Co.</i>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>L. Ford Cooney</i> (Address) <i>Deutschville, Md.</i>				
15 Filed <i>3/5</i> , 1914 <i>L. S. Herbert</i> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <i>Mar. 4</i> , 1914 (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <i>Mar. 3</i> , 1914, to <i>Mar. 4</i> , 1914, that I last saw him alive on <i>Mar. 3</i> , 1914, and that death occurred on the date stated above, at <i>8 a. m.</i>				
The CAUSE OF DEATH* was as follows: <i>Autogenous metastases dependent on carcinoma of the stomach peritonitis</i> (Duration) _____ yrs. _____ mos. <i>1</i> ds. Contributory (Secondary) <i>Cardiac Failure</i> (Duration) _____ yrs. _____ mos. <i>1/2</i> ds. (Signed) <i>Francis E. Jamison</i> , M. D. <i>3/5</i> , 1914 (Address) <i>Wheaton</i>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <i>Old Hill's Cemetery</i>				DATE OF BURIAL <i>3/6</i> , 1914
20 UNDERTAKER <i>G. A. Deak</i>				ADDRESS <i>Du Bois</i>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

2720

78

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty CharlesRegistration Dist. No. 100Village or City La Plena (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Hawkins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Aug 20th, 1892
(Month) (Day) (Year)

7 AGE 27 yrs. 7 mos. with 14 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laundry man
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Ches Co.

PARENTS
10 NAME OF FATHER Denial Hawkins
11 BIRTHPLACE OF FATHER (State or country) Ches Co.
12 MAIDEN NAME OF MOTHER Helen Bernso
13 BIRTHPLACE OF MOTHER (State or country) Ches Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen Bernso(Address) La Plena

15 Filed Michs. 15, 1914 R. H. Hampton
Treas. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1913, to Mar 13, 1914,

that I last saw him alive on Mar 11, 1914and that death occurred on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion(Duration) _____ yrs. _____ mos. 21 ds.

Contributory (Secondary)

Pulmonary Tuberculosis(Duration) 1 yrs. 5 mos. _____ ds.(Signed) E. H. H. H., M. D.Mar 14, 1914 (Address) Box 100

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New York Michs. 15, 1914

20 UNDERTAKER ADDRESS

Samuel V. Penn La Plena

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Transition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 8 1914

BUREAU, U. S.

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1 PLACE OF DEATH County <u>Charles</u>			2721	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Pomonkey</u> (No.) St; Ward			Registered No. <u>106</u>		
2 FULL NAME <u>Danberry Vernon</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>June 1, 1913</u> (Month) (Day) (Year)					
7 AGE yrs. <u>9</u> mos. <u>30</u> ds. If LESS than 1 day.....hrs. OR.....min.?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>near Pomonkey</u>					
PARENTS	10 NAME OF FATHER <u>George Vernon</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Charles Co</u>				
	12 MAIDEN NAME OF MOTHER <u>Ida Quinn</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Charles Co</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Quinn</u> (Address) <u>Pomonkey</u>					
15 Filed <u>March 31, 1914</u> <u>C. H. Marshall</u> <u>D. P. Sevel</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 31, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>March 19, 1914</u> , to <u>March 19, 1914</u> , that I last saw him alive on <u>March 19, 1914</u> and that death occurred on the date stated above, at <u>3-50 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Pneumonia (acute) not treated at my office I saw it but once</u> (Duration) yrs. mos. ds.					
Contributory (Secondary) (Duration) yrs. mos. ds.					
(Signed) <u>J. W. Mitchell</u> , M. D. <u>March 31, 1914</u> (Address) <u>Indian Head</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.....					
19 PLACE OF BURIAL OR REMOVAL <u>Pomonkey Cem.</u>				DATE OF BURIAL <u>April 2, 1914</u>	
20 UNDERTAKER <u>Wm. Mahoney</u>				ADDRESS <u>Accokeek</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

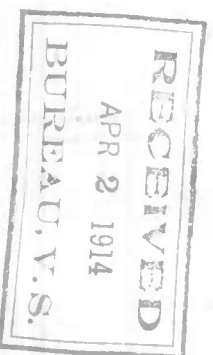
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 2722

County CharlesVillage or City Maryburg (No. _____, _____ St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 108

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edmund Henson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Unknown, 1 _____
(Month) (Day) (Year)

7 AGE 54(?) yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Gun Powder Works

9 BIRTHPLACE (State or country) Charles Co, Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Henson

13 BIRTHPLACE OF MOTHER (State or country) Charles Co, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Hawkins(Address) Pisgah Md. (ing)

15 Filed March 2, 1914 DeLutherland
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 1, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1913, to Feb 8, 1914.

that I last saw him alive on Feb 8, 1914.

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis
Cardiac Valvular Disease

(Duration) 15 yrs. _____ mos. _____ ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. C. Bicknell, M. D.
March 2, 1914 (Address) Pisgah, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT, OR RECENT RESIDENTS)

All place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Smith Chapel Church DATE OF BURIAL March 3, 1914

20 UNDERTAKER Ed Carpenter ADDRESS Pisgah Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

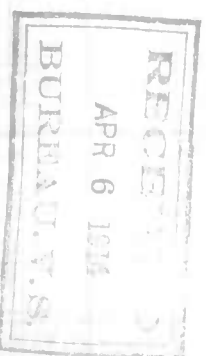
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saltzman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of:..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 2723

189

County CharlesVillage or City Piquette (No. _____)

St. _____ Ward _____

Registration Dist. No. 101

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH March 13, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. OR _____ min. ?
It LESS than 1 day, _____ hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Ed Henson
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Charles Co Md

10 NAME OF FATHER San Henson

11 BIRTHPLACE OF FATHER (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Lizzie Travers

13 BIRTHPLACE OF MOTHER (State or country) Charles Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary L. Bragans(Address) Piquette Md

15 Filed March 14, 1914 W. A. Luthersland
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unknown

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. A. Luthersland, M. D.

March 14, 1914 (Address) Piquette Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL Smith Chapel DATE OF BURIAL March 14, 1914

20 UNDERTAKER W. A. Luthersland ADDRESS Piquette Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

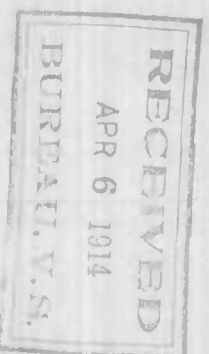
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Iunition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Charles</u>		2724 CH 3 (92)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Marbury</u> (No. _____)		St.; _____ Ward _____		Registration Dist. No. <u>161</u>	
2 FULL NAME <u>William Jackson</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>March 7, 1854</u> (Month) (Day) (Year)					
7 AGE <u>60</u> yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farm Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Charles Co., Md.</u>					
PARENTS	10 NAME OF FATHER <u>Vernel Jackson</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Charles Co., Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Emily Jendler</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Charles Co.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jos. Jordan</u> (Address) <u>Marbury Md (P)</u>					
15 Filed <u>March 21, 1914</u> <u>W. S. Sutherland</u> REGISTRAR <u>T. C. C.</u>					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 20, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>March 19, 1914</u> to <u>March 19, 1914</u> that I last saw him alive on <u>March 19, 1914</u> and that death occurred on the date stated above, at <u>4:50 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Pneumonia Lobar</u> <u>2 mo</u> (Duration) _____ yrs. _____ mos. <u>7</u> ds.					
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>J. C. Bicknell</u> M. D. <u>March 20, 1914</u> (Address) <u>Pisgah, Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Mount Hope</u>				DATE OF BURIAL <u>Mar 22, 1914</u>	
20 UNDERTAKER <u>C. D. Carpenter</u>				ADDRESS <u>Pisgah Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

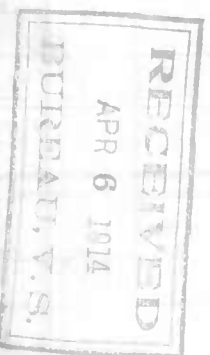
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Repetec wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

St. Charles

2725

35

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

*284*Village or City *Ches. Market*

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sophia R. Kellogg

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*
(Write the word)

6 DATE OF BIRTH

unknown, 11.5.43
(Month) (Day) (Year)

7 AGE

71 yrs. mos. ds. 11 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Unknown

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. M. Lyon

(Address)

Ryeoville, Ind.

15

Filed

Mar. 10th, 1914*Zach. R. Morgan*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 10th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 24th, 1914, to *Mar. 10th*, 1914.that I last saw her alive on *March 7th*, 1914.and that death occurred on the date stated above, at *2 P. m.*

The CAUSE OF DEATH* was as follows:

Disseminated Tuberculosis of knee joint, and left maxillary bone

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) *Zach. R. Morgan*, M. D.*Mar. 10th*, 1914. (Address) *Mechanicville, Ind.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

All Faith Cemetery *March 11th*, 1914

20 UNDERTAKER

ADDRESS

A. C. Welch *Chaplin*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—[Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAY 4 1914
BUREAU. V. S.

RECEIVED
APR 4 1914
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 2726 CH. 5
 County Charles
 Village or City Marbury (No. _____, St.; _____ Ward)
 2 FULL NAME Mary McDaniel
 Registration Dist. No. 101
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Feb 22, 1883
 (Month) (Day) (Year)

7 AGE 81 yrs. 12 mos. 12 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. At home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Charles Co. Md.

PARENTS
 10 NAME OF FATHER Ronald M. Daniel
 11 BIRTHPLACE OF FATHER (State or country) Charles Co. Md.
 12 MAIDEN NAME OF MOTHER Margaret Robey
 13 BIRTHPLACE OF MOTHER (State or country) Charles Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amel Skinner
 (Address) Marbury Md. 101

15 Filed March 8, 1914 Dr. Luchman
Free REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 6, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1914, to March, 1914.

that I last saw her alive on March 3, 1914

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Accidental Burns,
clothing caught fire from cook
stove.
W.B. (Duration) _____ yrs. _____ mos. 8 ds.

Contributory
 Secondary _____

(Signed) Geo. C. Picknill, M. D.
March 7, 1914. (Address) Pisgah Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Marbury Md DATE OF BURIAL Mar 8, 1914

20 UNDERTAKER C D Carpenter ADDRESS Pisgah Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

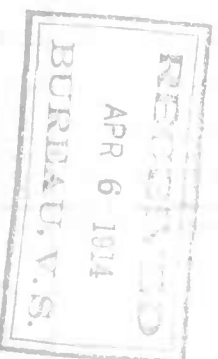
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal, peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Charles 2727Village or City Bruddick (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 108

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Bray, P. Messick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Jan 1, 1846
(Month) (Day) (Year)

7 AGE 68 yrs. 2 mos. 26 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer) Fishing & oystering

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Wm B Messick

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Elizabeth Insley

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Messick(Address) Bruddick md

15 Filed _____, 191____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1914 to March 27, 1914

that I last saw him alive on March 27, 1914

and that death occurred on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH was as follows:

Double Labor Pneumonia

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory (Secondary) Double Labor Pneumonia

(Signed) J D Chappeler, M. D.
March 27, 1914 (Address) Highville md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Asberry Chapel March 29, 1914

20 UNDERTAKER ADDRESS
Booy Herbert Highville md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tumult," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 2728

189

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty CharlesRegistration Dist. No. 106Village or City Maryland (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Eva P. Neal

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 7, 1913
(Month) (Day) (Year)

7 AGE _____ yrs. 10 mos. 29 ds. OR _____ min. ?
If LESS than 1 day, _____ hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Charles Co Md

PARENTS
10 NAME OF FATHER Augusta Neal
11 BIRTHPLACE OF FATHER (State or country) Charles Co Md
12 MAIDEN NAME OF MOTHER Eva P. Butler
13 BIRTHPLACE OF MOTHER (State or country) Charles Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Augusta Neal
(Address) Maryland Md

15 Filled March 7, 1914 Dr. L. L. Luthersland REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 4, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Indisposition
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) Dr. Luthersland, M. D.
March 7, 1914 (Address) Maryland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Cornwallace Rock DATE OF BURIAL March 7, 1914

20 UNDERTAKER L. L. Carpenter ADDRESS Pisgah Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

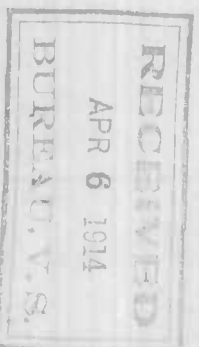
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		2729		C.H.		STATE OF MARYLAND CERTIFICATE OF DEATH	
County		Charles		(151)		Registration Dist. No. 100	
Village or City		La Plata		(No.)		St. Ward)	
2 FULL NAME		Joseph Perry Nelson					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)					
Male	Colored	Single					
6 DATE OF BIRTH	Dec 25, 1913						
(Month) (Day) (Year)							
7 AGE	If LESS than 1 day, hrs. yrs. 3 mos. ds. OR min. ?						
8 OCCUPATION	(a) Trade, profession, or particular kind of work. none						
(b) General nature of industry, business, or establishment in which employed (or employer)							
9 BIRTHPLACE (State or country)	Bryantown						
PARENTS	10 NAME OF FATHER	Perry Nelson					
	11 BIRTHPLACE OF FATHER (State or country)	Chas Co					
	12 MAIDEN NAME OF MOTHER	Kathryn York					
	13 BIRTHPLACE OF MOTHER (State or country)	Chas Co					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE							
(Informant)		John A Lee					
(Address)		La Plata Md					
15	Filed: Mch 22, 1914 R. Hampton Co						
REGISTRAR				16 DATE OF DEATH			
				Mch 22, 1914			
				(Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from 191... to 191... that I last saw him alive on 191... and that death occurred on the date stated above, at ... m. The CAUSE OF DEATH* was as follows:							
Deep cold sick since birth Grand mother state child had malarial fever							
(Duration) yrs. mos. ds.							
Contributory Secondarily no other in attendance (Duration) yrs. mos. ds.							
(Signed) R. Hampton Co, M. D. Mch 22, 1914 (Address) La Plata							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)							
At place of death yrs. mos. ds.				In the State yrs. mos. ds.			
Where was disease contracted, if not at place of death?							
Former or usual residence							
19 PLACE OF BURIAL OR REMOVAL				DATE OF BURIAL			
Brices Chapel				Mch 22, 1914			
20 UNDERTAKER				ADDRESS			
Robt R. Johnson				La Plata			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 3 1914
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

2730

 114 #3
 92
County CharlesSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 104Village or City Rock Point (No. _____)

St. _____ Ward _____

 [If death occurred in
 a hospital or institution,
 give its NAME instead
 of street and number.]
2 FULL NAME George B. Harris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Nov

(Month)

(Day)

(Year)

1891

7 AGE

53

yrs.

mos.

ds.

 If LESS than
 1 day, _____ hrs.
 OR _____ min. ?

8 OCCUPATION

 (a) Trade, profession, or
 particular kind of work
Fishman
 (b) General nature of industry,
 business, or establishment in
 which employed (or employer)

9 BIRTHPLACE

(State or country)

St Marys Co

PARENTS

10 NAME OF FATHER

Thomas Harris

11 BIRTHPLACE OF FATHER

(State or country)

St Marys Co

12 MAIDEN NAME OF MOTHER

Lane Wise

13 BIRTHPLACE OF MOTHER

(State or country)

St Marys Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bob Simms

(Address)

Lesum Md

15

Filed March 3, 1914W. A. PealeDist. Local

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

3 - 2

(Month)

(Day)

(Year)

1914

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 20, 1914, to March 2, 1914,that I last saw him alive on March 2, 1914and that death occurred on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Heart coughlobes

(Duration)

yrs.

mos.

4 ds.

Contributory
SecondaryJK Pneumonia

(Duration)

yrs.

mos.

7 ds.

(Signed)

J. L. Hargrave

, M. D.

Mar. 3, 1914. (Address)May side
 *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
 CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
 SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

In the

of death _____ yrs. _____ mos. _____ ds.

State

yrs.

mos.

ds.

 Where was disease contracted,
 If not at place of death?
Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cobb Neck Catholic CemeteryMarch 4, 1914

20 UNDERTAKER

ADDRESS

Charles W. Roper & Son

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

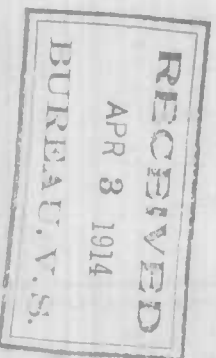
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease, CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scutle" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2731

92

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 100

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH
County CharlesVillage or City La Plata (No. _____, St.; _____ Ward)2 FULL NAME Evilina Penn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Oct 11, 1846
(Month) (Day) (Year)7 AGE 68 yrs. Oct 11 mos. 11 ds. OR 1 day, 11 hrs. 11 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9 BIRTHPLACE (State or country) Charles Es, Ind10 NAME OF FATHER George Dunmore11 BIRTHPLACE OF FATHER (State or country) Charles Es, Ind12 MAIDEN NAME OF MOTHER Lettie Dunmore13 BIRTHPLACE OF MOTHER (State or country) Charles Es, Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar Penn(Address) Spring Hill, Charles Es, Ind

15 Filed March 18, 1914 R. Hampton Cox
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from March 10, 1914, to March 17, 1914.that I last saw her alive on March 17, 1914.and that death occurred on the date stated above, at 9-45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Contributory Secondary

(Duration) about 10 yrs. 10 mos. 10 ds.(Signed) Thos. S. Owen, M. D.March 18, 1914 (Address) La Plata, Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 18 yrs. 10 mos. 10 ds. In the State 18 yrs. 10 mos. 10 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Cem. DATE OF BURIAL March 19, 191420 UNDERTAKER Tommy + Penn ADDRESS La Plata

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

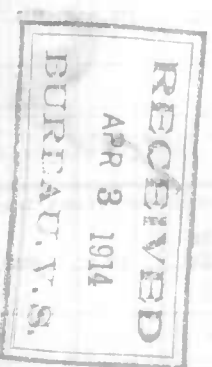
Approved by U. S. Census and American Public Health Association.¹

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 2732

County CharlesVillage or City Manfemay (No. _____, _____)Registration Dist. No. 152

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stell BornPenny

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>None</u>
6 DATE OF BIRTH <u>March 17</u> , 1914 (Month) (Day) (Year)		
7 AGE <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		
9 BIRTHPLACE (State or country) <u>Chas Co Ind</u>		
PARENTS	10 NAME OF FATHER <u>Samus Penny</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Chas Co Ind</u>	
	12 MAIDEN NAME OF MOTHER <u>Ethel Key</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Chas Co Ind</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samus Butler(Address) Manfemay Ind

15

Filed March 1914William B. Thompson REGISTRARSTATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw h_____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m,

The CAUSE OF DEATH* was as follows:

Stell Born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) William B. Thompson, M. D.
March 18, 1914. (Address) Concester Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Emory Chapel

DATE OF BURIAL

March 18, 1914

20 UNDERTAKER

Samus Butler

ADDRESS

Manfemay Ind

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

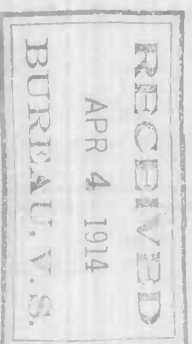
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2733

28

County Chas.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 100Village or City Pomfret (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Hugh Walter Rabey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widower
(Write the word)

6 DATE OF BIRTH March 18, 1834
(Month) (Day) (Year)7 AGE 80 yrs. — mos. 7 ds. OR 1 day, — hrs. — min. ?
It LESS than8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) State

PARENTS
10 NAME OF FATHER Uriah Rabey?
11 BIRTHPLACE OF FATHER (State or country) unknown
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pearl Hancock Rabey(Address) Pomfret, Md.15 Filed March 26, 1914 P. D. [unclear] [unclear] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 25, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from March 24, 1914, to March 24, 1914,
that I last saw him alive on March 24, 1914and that death occurred on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:Cardiac "collapse"Contributory Tuberculosis of lungs
(Duration) — yrs. — mos. — ds.
Secondary(Signed) Jas. J. Edelen, M. D.
March 26, 1914 (Address) La Plata, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. in the State — yrs. — mos. — ds.
Where was disease contracted, if not at place of death?
Former or usual residence19 PLACE OF BURIAL OR REMOVAL Pomfret, Md. DATE OF BURIAL March 27, 1914
20 UNDERTAKER Lomax & Penn ADDRESS La Plata

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

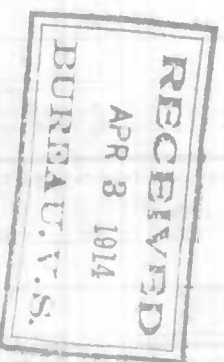
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

2734

(120)

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Charles

Registration Dist. No. 105

Village or City

White Plains

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Winnifred R. Robey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

April

1868

(Month)

(Day)

(Year)

7 AGE

46

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Chas. Co.

PARENTS

10 NAME OF FATHER

Richard Drillet

11 BIRTHPLACE OF FATHER (State or country)

Chas. Co.

12 MAIDEN NAME OF MOTHER

Melvinia Montgomery

13 BIRTHPLACE OF MOTHER (State or country)

Chas. Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John S. Robey

(Address)

White Plains

15

Filed

3/10

1914

J. M. Wilkerson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar

(Month)

(Day)

1914

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 18

1914

to

Mar 10

1914

that I last saw him alive on

Mar 4

1914

and that death occurred on the date stated above, at

7 a. m.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning

(Duration)

yrs.

mos.

10 ds.

Contributory (Secondary)

Chronic Bright's Disease

(Duration)

yrs.

mos.

7 ds.

(Signed)

J. H. Allen

M. D.

Mar 10, 1914

(Address)

Bel Air

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Pauls Cemetery

3/11

1914

20 UNDERTAKER

ADDRESS

Chas. H. Robey & Co.

Bel Air

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

2735 19

County CharlesSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 100Village or City New Town (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Bruce Jackson Reiser

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucas 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 9, 1899
(Month) (Day) (Year)

7 AGE 17 yrs. 8 mos. 7 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Chas. Co.

PARENTS
10 NAME OF FATHER Turner Jackson
11 BIRTHPLACE OF FATHER (State or country) Chas. Co.
12 MAIDEN NAME OF MOTHER Carrie Thomas
13 BIRTHPLACE OF MOTHER (State or country) Chas. Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. A. Reiser(Address) New Town

15 Filed June 14, 1914 R. H. H. Cox
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 11, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1914 to June 11, 1914

that I last saw him alive on June 2, 1914and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease(Duration) 51 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. J. H. H. Cox, M. D.June 14, 1914 (Address) Bre. Adams

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

West Hill Cemetery, La Plata June 14, 1914

20 UNDERTAKER ADDRESS

William Roby Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not salariedly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Transition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 3 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

2736

91

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Charles

Registration Dist. No. 103

Village or City

Bel Air

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Walter Smaun

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucas

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

July 10, 1913
(Month) (Day) (Year)

7 AGE

7 yrs. 23 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Charles C.

PARENTS

10 NAME OF FATHER

James M. Smaun

11 BIRTHPLACE OF FATHER
(State or country)

Chas C.

12 MAIDEN NAME OF MOTHER

Mamie A. Proctor

13 BIRTHPLACE OF MOTHER
(State or country)

Chas C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James M. Smaun

(Address)

Bel Air

15

Filed

Mar 8, 1914

Charles H. Roby
Jocel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 7, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 28, 1914, to Mar 7, 1914

that I last saw him alive on Feb 28, 1914

and that death occurred on the date stated above, at 5-102 p.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. 2 mos. 2 ds.

Contributory
(Secondary)

Bronch. Pneumonia

(Duration) yrs. 7 mos. 7 ds.

(Signed)

Mar 7, 1914 (Address) Bel Air

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Thomas Church

Mar 8, 1914

20 UNDERTAKER

ADDRESS

James M. Smaun

Bel Air

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

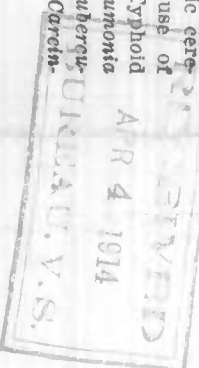
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculousness of lungs*, *meninges*, *peritoneum*, etc. *Carcinoma*, *Surcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS or INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Charles

Village or City Pisgah (No. _____, St.; _____ Ward)

2 FULL NAME none (Still-Birth) Taylor

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 101

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)
6 DATE OF BIRTH March 1st, 1914
(Month) (Day) (Year)
7 AGE Still-Born It LESS than
t day, _____ hrs.
yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Charles Co. Md.

PARENTS
10 NAME OF FATHER William J. Taylor
11 BIRTHPLACE OF FATHER (State or country) Chas. Co. Md.
12 MAIDEN NAME OF MOTHER Rosia Brown
13 BIRTHPLACE OF MOTHER (State or country) Chas. Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) Pisgah, Md.

15 Filed _____, 191_____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 1st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still-Born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. A. Louthersland
_____, 191____ (Address) Marbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Smiths' Chapel Cemetery DATE OF BURIAL March 2, 1914

20 UNDERTAKER C. D. Carpenter ADDRESS Pisgah, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Re-ent for S. H. O. Signature -
indicate signed
certificate)

RECEIVED
APR 6 1914
BUREAU V. S.

oma, *scarcum*, etc., of..... (Indicate origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 20 1914
BUREAU V. S.

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1 PLACE OF DEATH 2738		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Charles</u>		Registration Dist. No. <u>106</u>	
Village or City <u>Pomonkey</u> (No. _____)		St.; _____ Ward _____	
2 FULL NAME <u>Jane Thompson</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>Jan. 12, 1849</u> (Month) (Day) (Year)			
7 AGE <u>65</u> yrs. <u>2</u> mos. <u>1</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			
9 BIRTHPLACE (State or country) <u>Chas. Co. Md.</u>			
PARENTS	10 NAME OF FATHER <u>Ace Simons</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>		
	12 MAIDEN NAME OF MOTHER <u>Elyza Barnes</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sidney Thompson</u> (Address) <u>Pomonkey, Md.</u>			
15 Filed <u>Mch. 16, 1914</u>		C. H. Marshall <u>Dep. Local</u> REGISTRAR	
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Mch. 13, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Edw.</u> , 191 <u>3</u> , to <u>10 March, 1914</u> , that I last saw her alive on <u>10 March, 1914</u> , and that death occurred on the date stated above, at _____ m, The CAUSE OF DEATH* was as follows: <u>Infected (?) Kidneys</u> <u>Not Completed Diagnosis</u> <u>General Debility</u> (Duration) _____ yrs. _____ mos. _____ ds. <u>Uremia</u> Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>E. Mayfield Bayle</u> , M. D. <u>13 years, 1914</u> (Address) <u>704 12th St. S.E.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Pomonkey Cem.</u>		DATE OF BURIAL <u>Mch. 16, 1914</u>	
20 UNDERTAKER <u>Wm. Mahoney</u>		ADDRESS <u>Accokeek Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

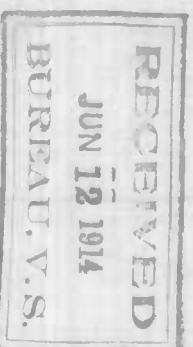
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less ~~definite~~ ^{definite} ~~use of~~ ^{use of} "Punier" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



sent out for signature;
data received and doctors
prescription blank.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

2739

74

County

Charles

Village or City

Piegah

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John H. Turner.

Registration Dist. No. 101

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married (Write the word)

6 DATE OF BIRTH

Apr 18, 1835

7 AGE

78 yrs. 11 mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Charles Co. Md.

PARENTS

10 NAME OF FATHER

Geo. Turner.

11 BIRTHPLACE OF FATHER (State or country)

Charles Co. Md.

12 MAIDEN NAME OF MOTHER

Hattie Jones

13 BIRTHPLACE OF MOTHER (State or country)

Charles Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nancy Turner

(Address)

Piegah Md (93)

15

Filed March 14, 1914

T. H. Buckenbark

Local

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mch 14, 1914

17

I HEREBY CERTIFY, That I attended deceased from

Janu 1914 to Mch 14, 1914

that I last saw him alive on Mch 14, 1914

and that death occurred on the date stated above, at 10:40 p.m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart
Chr. Valvular Disease
Chr. Myocarditis.

(Duration) 9 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) G. C. Bicknell, M. D.
Mch 14, 1914 (Address) Piegah, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Alexander Chapel

March 17, 1914

20 UNDERTAKER

ADDRESS

W. B. Thompson

Pronaids

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

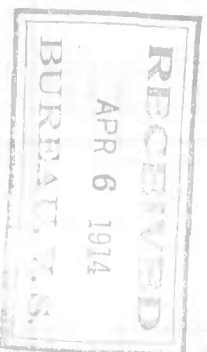
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

2740

S

County

Charles

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

100

Village or City

Spring Hill

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Wallace

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

African

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Mar 1, 1914
(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Charles County

PARENTS

10 NAME OF FATHER

Henry H. Wallace

11 BIRTHPLACE OF FATHER
(State or country)

Chas. Co.

12 MAIDEN NAME OF MOTHER

Annie Howard

13 BIRTHPLACE OF MOTHER
(State or country)

Chas. Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry H. Wallace

(Address)

Spring Hill

15

Filed

Mar 10, 1914 R. H. Hauptman
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)
1914

17

I HEREBY CERTIFY, That I attended deceased from

1914, to 1914,

that I last saw him alive on 1914

and that death occurred on the date stated above, at m,

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. H. H.

M. D.

Mar 1, 1914 (Address) Bee Aesha

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS; INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Rest LaPlata

Mar 2, 1914

20 UNDERTAKER

ADDRESS

Henry H. Wallace

LaPlata

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 3 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Chas.Village or City Brentland (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 1032

St.; _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Louisa Warren

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH

X X 1870
(Month) (Day) (Year)

7 AGE

44 yrs. — mos. — ds. OR — min. ?
It LESS than 1 day, _____ hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE
(State or country)County (Chas.)

PARENTS

10 NAME OF FATHER

Joe Lee11 BIRTHPLACE OF FATHER
(State or country)State

12 MAIDEN NAME OF MOTHER

Jone unknown13 BIRTHPLACE OF MOTHER
(State or country)State

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Yancy Warren(Address) Brentland

15

Filed

March 15, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 15, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Nov. —, 1913 to Feb. 14, 1914.that I last saw her alive on Feb. 14, 1914and that death occurred on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia(Duration) — yrs. 8 mos. — ds.Contributory
Secondary(Duration) — yrs. — mos. — ds.(Signed) Jas J. Edelen, M. D.March 15, 1914 (Address) La Plata

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Little RiverMarch 15, 1914

20 UNDERTAKER

ADDRESS

H. B. ThompsonDoncaster

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

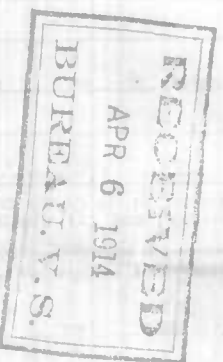
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

2742

40

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Charles

Registration Dist. No.

108

Village or City

Hughesville (No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Peter S. Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Mar 1851 23, 1851
(Month) (Day) (Year)

7 AGE

62 yrs. 11 mos. 29 ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Md

PARENTS

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alvin Williams

(Address)

Hughesville Md

15

Filed

March 22, 1914 J. H. Chappell
Hughesville Md REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 20, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 18, 1914, to Mar 20, 1914

that I last saw him alive on Mar 19th, 1914

and that death occurred on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastric Cancer

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. M. Norton, M. D.

Mar 20, 1914. (Address) Hughesville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Joseph's Church
Hughesville Md Mar 22, 1914

20 UNDERTAKER

ADDRESS

Chas. H. H. H. Hughesville Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

